South Carolina Retirement Systems

Service and Disability Retirement Claims

Disclaimer

THIS PRESENTATION DOES NOT CREATE AN EXPRESS OR IMPLIED CONTRACT OF EMPLOYMENT WITH A MEMBER OF THE SOUTH CAROLINA RETIREMENT SYSTEMS.

This presentation is meant to serve as a guide but does not constitute a binding representation of the South Carolina Retirement Systems. The statutes governing the South Carolina Retirement Systems are found in Title 9 of the South Carolina Code of Laws, and should there be any conflict between this presentation and the statutes or Retirement Systems' policies, the statutes and policies will prevail.

Employers covered by the South Carolina Retirement Systems are not agents of the Retirement Systems.

Service Retirement Applications

SCRS Service Retirement

- **Full Service – Age 65 or 28 years of service (9-1-1510 and 9-1-1550)***
- **Early Retirement – Age 60 (reduction is 5% for each year under age 65) or age 55 with at least 25 years of service (reduction is 4% for each year of service less than 28) (9-1-1515 and 9-1-1550)***
- **Applications can be made no earlier than 6 months prior to or 90 days after the date of retirement (9-1-1510 and 9-1-1515)**
- **Application should be submitted 3 to 6 months in advance of expected retirement date if possible**

***A deferred annuity based on age eligibility requires five years of service. The five years must be earned service if membership began on or after January 1, 2001.**

Teacher and Employee Retention Incentive (TERI) (9-1-2210)

- TERI (a deferred retirement option plan)
- No interest on accrued TERI account
- Member is retired from the Retirement Systems
- TERI participant's AFC will not increase
- TERI participant no longer earns service credit
- Monthly retirement annuity payments are placed in a member's TERI account and are distributed when the member terminates employment

SCRS TERI Retirement

- **Same rules apply as regular retirement for eligibility and timely filing of a retirement application with one exception:**
  - **Date of retirement for TERI must be the day following the date of termination (9-1-2210); therefore, TERI date may not be retroactive.**
- **TERI participation cannot exceed 60 months (60 monthly retirement checks)**
- **If the first month of retirement is a partial month, it counts as the first full month of TERI**

SCRS TERI Retirement

- **If the member was previously retired and received a retirement benefit, the member may not participate in TERI. (9-1-2210 (l))**

SCRS Retirement Formula

- **Class II (Average Final Compensation x years of service x 0.0182) or Class I (Average Final Compensation x years of service x 0.0145)**
  - **Result represents annual unreduced benefit for maximum (Option A) payment plan**
  - **Divide by 12 for standard monthly benefit**
  - **Apply early retirement reduction factor and/or joint- survivor factor (Option B or C)**

Form 6101S
SCRS Service Retirement Application

FOR DATES OF RETIREMENT OF JANUARY 1, 2001, OR AFTER

Form 6101S
Revised 05/22/2001
Page 1

SCRS SERVICE RETIREMENT APPLICATION
State Budget and Control Board
South Carolina Retirement Systems
P.O. Box 11960, Columbia, SC 29211-1960

The member must be off the payroll as of the effective date of retirement. Applications for retirement may be filed as early as six months prior to, and up to three months after, your service retirement effective date.

OFFICE USE ONLY
☐ SCRS
☐ Correlated _____
☐ Disability pending
☐ TERI Participant

Section I (Attach Your Birth Certificate) **PERSONAL INFORMATION** TYPE OR PRINT IN BLUE INK

LAST NAME & SUFFIX (Jr., Sr., etc.)	FIRST/MIDDLE NAME	SOCIAL SECURITY NUMBER
DOE	JOHN E	123-45-6789

Address	Date of Birth (proof required)	Sex (M=Male F=Female)
123 MAIN STREET	07-01-1945	M

City	State	ZIP+4	Home Phone	Work Phone
ANYTOWN	SC	29123	803-123-4567	803-765-4321

Section II **SCRS RETIREMENT PLAN ELECTION AND BENEFICIARY DESIGNATION**

YOUR PAYMENT PLAN MAY NOT BE CHANGED ONCE BENEFITS HAVE BEGUN AFTER RETIREMENT, except as noted on the reverse side. If designating more than three beneficiaries, complete and attach an additional Form 6101S. For all plans, attach a copy of your birth certificate. For any joint retiree-survivor plan, attach your beneficiary's birth certificate.

☐ Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust.

☒ OPTION A (Maximum-Retiree Only) ☐ OPTION B (100% - 100% Joint Retiree-Survivor) ☐ OPTION C (100% - 50% Joint Retiree-Survivor)

	Social Security #/Federal ID#	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary: JANE R DOE	987-65-4321	☐ M ☒ F	12-01-1947	☒ Spouse ☐ Son ☐ Daughter ☐ Other
2. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section III ☒ RETIREE GROUP LIFE INSURANCE CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II

1. Name of Beneficiary	Social Security #/Federal ID#	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
2. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section IV **EMPLOYMENT INFORMATION**

Current/Former Employer(s)	Your Position Title
ANY EMPLOYER	EMPLOYEE

Last day on payroll will be or was: 06-30-2003

Effective Date of Retirement (choose one): ☒ Day following last day on payroll ☐ Specific date: _____

Do you plan to defer your retirement benefits through the Teacher and Employee Retention Incentive (TERI) program? ☒ Yes ☐ No
If yes, please attach a completed Form 6201 from your employer indicating the dates of your TERI period.

Section V **SIGNATURE AND NOTARY STATEMENT**

Please read the Authorization section of the instructions on the reverse (page 2) before signing this form IN BLUE INK.

I hereby certify I have read and understand the information on the reverse side (page 2), including the authorization, and I agree to the terms stated.

MEMBER'S SIGNATURE _____ DATE _____

WITNESS _____ DATE _____
(Certified copy of legal authorization required with signature other than applicant's)

STATE OF _____ COUNTY OF _____
(Required only when signed by mark)

Acknowledged before me this date _____ NOTARY NAME _____

My commission expires _____ NOTARY SIGNATURE _____

Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or (803) 737-6800

PORS Service Retirement

- **Full Service – 25 years of service or age 55 with at least 5 years of service (9-11-60)***
- **Early Retirement – PORS does not have an early retirement provision**
- **Applications can be made no earlier than 6 months prior to or 90 days after the date of retirement (9-11-60)**
- **Application should be submitted 3 to 6 months in advance of expected retirement date if possible**
- **PORS members not eligible for TERI**

***Five years of earned service required if membership began on or after January 1, 2001.**

PORS Retirement Formula

- **Class I Service Formula – $10.97 monthly for each year of service equals monthly retirement benefit (less any Option B or C payment plan joint-survivor option factor)**
- **Class II Service Formula – Average Final Compensation x years of service x 0.0214**
  - **Result represents annual unreduced benefit for maximum (Option A) payment plan**
  - **Divide by 12 for standard monthly benefit**
  - **Apply joint-survivor option factor (Option B or C)**

Form 6101P
PORS Service Retirement Application with Checklist

FOR DATES OF RETIREMENT OF JANUARY 1, 2001, OR AFTER

Form 6101P
Revised 06/08/2001
Page 1

PORS SERVICE RETIREMENT APPLICATION

State Budget and Control Board
South Carolina Retirement Systems

The member must be off the payroll as of the effective date of retirement. Applications for retirement may be filed as early as six months prior to, and up to three months after, your service retirement effective date.

OFFICE USE ONLY
☐ **PORS**
☐ Correlated _____
☐ Disability pending
_____

Section I (Attach Your Birth Certificate) **PERSONAL INFORMATION** TYPE OR PRINT IN BLUE INK

LAST NAME & SUFFIX	FIRST/MIDDLE NAME	SOCIAL SECURITY NUMBER
DOE	JANE	546-41-1657

Address	Date of Birth (proof required)	Sex
202 ARBOR LAKE DR	08-15-1948	F (M=Male F=Female)

City	State	ZIP+4	Home Phone	Work Phone
COLUMBIA	SC	29211	803-789-6543	803-897-1234

Section II **PORS RETIREMENT PLAN ELECTION AND BENEFICIARY DESIGNATION**

YOUR PAYMENT PLAN MAY NOT BE CHANGED ONCE BENEFITS HAVE BEGUN AFTER RETIREMENT, except as noted on the reverse side. If designating more than three beneficiaries, complete and attach an additional Form 6101P. For all plans, attach a copy of your birth certificate. For any joint retiree-survivor plan, attach your beneficiary's birth certificate.

☐ Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust.

☐ OPTION A (Maximum-Retiree Only) ☒ OPTION B (100% - 100% Joint Retiree-Survivor) ☐ OPTION C (100% - 50% Joint Retiree-Survivor)

	Social Security #/Federal ID#	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary JOHN DOE	654-12-9873	☒ M ☐ F	05-12-1948	☒ Spouse ☐ Son ☐ Daughter ☐ Other
2. Name of Beneficiary JIMMY DOE	745-15-6579	☒ M ☐ F	08-23-1980	☐ Spouse ☒ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section III ☐ RETIREE GROUP LIFE INSURANCE CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II

	Social Security #/Federal ID#	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary JOHN DOE	654-12-9873	☒ M ☐ F	05-12-1948	☒ Spouse ☐ Son ☐ Daughter ☐ Other
2. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section IV **EMPLOYMENT INFORMATION**

Current/Former Employer(s)	Your Position Title
POLICE DEPT	OFFICER

Last day on payroll will be or was: 08-12-2003

Effective Date of Retirement (choose one): ☐ Day following last day on payroll ☒ Specific date: 08-15-2003

Section V **SIGNATURE AND NOTARY STATEMENT**

Please read the Authorization section of the instructions on the reverse (page 2) before signing this form IN BLUE INK.

I hereby certify I have read and understand the information on the reverse side (page 2), including the authorization, and I agree to the terms stated.

MEMBER'S SIGNATURE _____ DATE _____

WITNESS _____ (Certified copy of legal authorization required with signature other than applicant's) DATE _____

STATE OF _____ (Required only when signed by mark) COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My commission expires _____ NOTARY SIGNATURE _____

Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or (803) 737-6800

Disability Retirement Applications

SCRS Disability Retirement
(9-1-1540 & 9-1-1560)

- **Must have 5 years of service credit to be eligible* (waived if disability is a result of job-related injury)**
- **Must be in service to be eligible to apply for disability retirement**
- **Must be under age 65 at time of retirement**
- **Generally, will be in a reduced-work capacity (on annual/ sick leave, leave without pay, diminished capacity, or reduced hours)**
- **Must be mentally or physically incapacitated from performing employee's job duties and the incapacitation must be permanent**
- **Earliest retirement date is 30 days from date application is received or day after termination, whichever is later**

***Five years of earned service required if membership began on or after January 1, 2001, unless job-related disability.**

Form 6151S

SCRS Disability Retirement Application with Checklist

FOR DATES OF RETIREMENT OF JANUARY 1, 2001, OR AFTER

Form 6151S
Revised 04/03/2002
Page 1

SCRS DISABILITY RETIREMENT APPLICATION
State Budget and Control Board
South Carolina Retirement Systems
P.O. Box 11960, Columbia, SC 29211-1960

Applications for disability retirement must be filed while you are on your employer's payroll in a paid or approved unpaid capacity. If you are unable to complete this application, a designee (employer, legal counsel, power of attorney) may complete the application on your behalf, but may not complete method of payment or beneficiary information. Please see the reverse side for information about retirement effective dates.

OFFICE USE ONLY
☐ **SCRS**
☐ Correlated _____
☐ Date first eligible for disability retirement _____
☐ Service application on file

Section I (Attach Your Birth Certificate) **PERSONAL INFORMATION** TYPE OR PRINT IN BLUE INK

LAST NAME & SUFFIX (Jr., Sr., etc.)	FIRST/MIDDLE NAME	SOCIAL SECURITY NUMBER
TEACHER	CINDY S	456-98-1237

Address	Date of Birth (proof required)	Sex
123 SCHOOLHOUSE ST	12-31-1960	F (M=Male F=Female)

City	State	ZIP+4	Home Phone	Work Phone
GREENVILLE	SC	29600	864-294-1130	864-165-6484

Section II **SCRS RETIREMENT PLAN ELECTION AND BENEFICIARY DESIGNATION**

YOUR PAYMENT PLAN MAY NOT BE CHANGED ONCE BENEFITS HAVE BEGUN AFTER RETIREMENT, except as noted on the reverse side. If designating more than three beneficiaries, complete and attach an additional Form 6151S. For all plans, attach a copy of your birth certificate. For any joint retiree-survivor plan, attach your beneficiary's birth certificate.

☐ Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust.

☐ OPTION A (Maximum-Retiree Only) ☐ OPTION B (100% - 100% Joint Retiree-Survivor) ☒ OPTION C (100% - 50% Joint Retiree-Survivor)

	Social Security #/Federal ID#	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary JOE TEACHER	111-12-1348	☒ M ☐ F	04-12-1958	☒ Spouse ☐ Son ☐ Daughter ☐ Other
2. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section III ☐ RETIREE GROUP LIFE INSURANCE CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II

	Social Security #/Federal ID#	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary JOE TEACHER JR.	564-41-8971	☒ M ☐ F	01-25-1979	☐ Spouse ☒ Son ☐ Daughter ☐ Other
2. Name of Beneficiary MARY TEACHER	Social Security # 132-48-6479	☐ M ☒ F	Date of Birth 05-19-1984	☐ Spouse ☐ Son ☒ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section IV **EMPLOYMENT INFORMATION**

Current/Former Employer(s)	Your Position Title
SCHOOL DISTRICT	TEACHER

(Check one)
☐ Currently on employer's payroll in a paid capacity
☒ Currently on employer's payroll in an unpaid capacity.
My unpaid leave of absence began: 05-11-2003
☐ Last day on payroll was:

☒ If disability is the result of a job-related injury, check this box and attach employer's first report of injury form.
☐ If receiving Workers' Compensation benefits check here.

Section V **SIGNATURE AND NOTARY STATEMENT**

Please read the Authorization section of the instructions on the reverse (page 2) before signing this form IN BLUE INK.

I hereby certify I have read and understand the information on the reverse side (page 2), including the authorization, and I agree to the terms stated.

MEMBER'S SIGNATURE _____ DATE _____

(Certified copy of legal authorization required with signature other than applicant's)

WITNESS _____ DATE _____

(Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My commission expires _____ NOTARY SIGNATURE _____

Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or (803) 737-6800

PORS Disability Retirement
(9-11-80)

- **Must have 5 years of service credit to be eligible* (waived if disability is a result of job-related injury)**
- **Must be in-service to be eligible to apply for disability retirement**
- **Must be under age 55 at time of retirement**
- **Generally, will be in a reduced-work capacity (on annual/ sick leave, leave without pay, diminished capacity, or reduced hours)**
- **Must be mentally or physically incapacitated from performing employee's job duties and the incapacitation must be permanent**
- **Earliest retirement date is 30 days from date application received or day after last day on payroll, whichever is later**

***Five years of earned service required if membership began on or after January 1, 2001, unless job-related disability.**

Form 6151P

PORS Disability Retirement Application with Checklist

FOR DATES OF RETIREMENT OF JANUARY 1, 2001, OR AFTER

Form 6151P
Revised 06/08/2001
Page 1

PORS DISABILITY RETIREMENT APPLICATION

State Budget and Control Board
South Carolina Retirement Systems
P.O. Box 11960, Columbia, SC 29211-1960

Applications for disability retirement must be filed while you are on your employer's payroll in a paid or approved unpaid capacity. If you are unable to complete this application, a designee (employer, legal counsel, power of attorney) may complete the application on your behalf, but may not complete method of payment or beneficiary information. Please see the reverse side for information about retirement effective dates.

OFFICE USE ONLY
☐ **PORS**
☐ Correlated _____
☐ Date first eligible for disability retirement _____
☐ Service application on file

Section I (Attach Your Birth Certificate) **PERSONAL INFORMATION** TYPE OR PRINT IN BLUE INK

LAST NAME & SUFFIX (Jr., Sr., etc.)	FIRST/MIDDLE NAME	SOCIAL SECURITY NUMBER
LAW	JOHN Q	987-65-1234

Address	Date of Birth (proof required)	Sex
1 CIRCUIT CT	08-06-1975	M (M=Male F=Female)

City	State	ZIP+4	Home Phone	Work Phone
CHARLESTON	SC	29431	843-654-1379	843-976-5120

Section II **PORS RETIREMENT PLAN ELECTION AND BENEFICIARY DESIGNATION**

YOUR PAYMENT PLAN MAY NOT BE CHANGED ONCE BENEFITS HAVE BEGUN AFTER RETIREMENT, except as noted on the reverse side.
If designating more than three beneficiaries, complete and attach an additional Form 6151P. For all plans, attach a copy of your birth certificate. For any joint retiree-survivor plan, attach your beneficiary's birth certificate.

☐ Check here if payments are to be paid through a trust and attach a completed Form 1113, Certification of Trust.

☒ OPTION A (Maximum-Retiree Only) ☐ OPTION B (100% - 100% Joint Retiree-Survivor) ☐ OPTION C (100% - 50% Joint Retiree-Survivor)

	Social Security #/Federal ID#	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary ESTATE		☐ M ☐ F		☐ Spouse ☐ Son ☐ Daughter ☐ Other
2. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section III ☒ RETIREE GROUP LIFE INSURANCE
CHECK IF SAME BENEFICIARY(IES) AS IN SECTION II

	Social Security #/Federal ID#	Sex	Date of Birth	Relationship (Check one)
1. Name of Beneficiary		☐ M ☐ F		☐ Spouse ☐ Son ☐ Daughter ☐ Other
2. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other
3. Name of Beneficiary	Social Security #	☐ M ☐ F	Date of Birth	☐ Spouse ☐ Son ☐ Daughter ☐ Other

Section IV **EMPLOYMENT INFORMATION**

Current/Former Employer(s)	Your Position Title
COUNTY GOVERNMENT	DEPUTY

(Check one)
☒ Currently on employer's payroll in a paid capacity
☐ Currently on employer's payroll in an unpaid capacity.
My unpaid leave of absence began: _____
☐ Last day on payroll was:

☒ If disability is the result of a job-related injury, check this box and attach employer's first report of injury form.

Section V **SIGNATURE AND NOTARY STATEMENT**

Please read the Authorization section of the instructions on the reverse (page 2) before signing this form IN BLUE INK.

I hereby certify I have read and understand the information on the reverse side (page 2), including the authorization, and I agree to the terms stated.

MEMBER'S SIGNATURE _____ DATE _____

(Certified copy of legal authorization required with signature other than applicant's)

WITNESS _____ DATE _____

(Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My commission expires _____ NOTARY SIGNATURE _____

Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or (803) 737-6800

Employer Forms

Form 6201

Employer Certification of Last Day Paid

Form 6201
Revised 05/08/2003

EMPLOYER CERTIFICATION OF LAST DAY PAID

State Budget and Control Board - South Carolina Retirement Systems
Customer Annuity Claims
PO Box 11960, Columbia SC 29211-1960

Please attach to retirement application or fax to - Customer Annuity Claims' Unit at 803-737-7752. The purpose of this information is to determine an effective date of retirement for estimated payroll purposes.

Retiring Member's Name: ANY RETIREE SSN: 123-45-6789

Planned Retirement Date: 07-01-2003 ☒ SCRS ☐ PORS ☐ GARS ☐ JSRS

Section I **SERVICE OR DISABILITY RETIREMENT INFORMATION**

Please indicate the last day the employee earned compensation or is expected to earn compensation from your agency (last day of paid employment from which employee retirement contributions were or will be deducted): 06-30-2003

Even if the employee's actual termination date from your payroll will be the same as the date given above or will be after the date given above (due to workers' compensation, disability leave of absence without pay, Teacher and Employee Retention Incentive (TERI) program participation, etc.), **please indicate the employee's actual date of termination for retirement purposes only:** 06-30-2003

Employer Name: ANY EMPLOYER Employer Code: ###.##

Completed by: AUTHORIZED REPRESENTATIVE Job Title: BENEFITS ADMINISTRATOR

Phone Number: 803-123-4567 Fax Number: 803-987-6543

Authorized Employer Signature:_____ Date: _____

Section II **FOR TEACHER AND EMPLOYEE RETENTION INCENTIVE PROGRAM PARTICIPANTS ONLY**

This is to certify that in conjunction with the above-named member's SCRS service retirement, the member and employer acknowledge the member's participation in the Teacher and Employee Retention Incentive (TERI) program on the TERI start date below and the termination of his or her participation on the TERI end date below:

TERI Start Date: _____ (DATE OF RETIREMENT) TERI End Date: _____ Number of Months: _____ (MAXIMUM OF 60 MONTHS)

_____ TERI Participant's (Employee's) Signature

Date: _____

_____ TERI Employer's Authorized Signature

Date: _____

* For TERI participation, this termination date should be no more than one day prior to TERI start date (effective date of retirement) so as to certify that the member was actively employed upon TERI participation. For all retirees, complete Section I. For TERI retirees, complete Sections I and II.

Please complete this form and attach it to the member's application for retirement.

Please submit a corrected copy as soon as possible should any information change. The TERI participant or employer should notify the Retirement Systems' Payroll Department, either by telephone or in writing, three months prior to the TERI participant's TERI ending date.

Form 6201
Revised 05/08/2003
Page 1 of 2

EMPLOYER CERTIFICATION OF LAST DAY PAID

State Budget and Control Board - South Carolina Retirement Systems
Customer Annuity Claims
PO Box 11960, Columbia SC 29211-1960

Please attach to retirement application or fax to - Customer Annuity Claims' Unit at 803-737-7752. The purpose of this information is to determine an effective date of retirement for estimated payroll purposes.

Retiring Member's Name: ANY RETIREE SSN: 123-45-6789

Planned Retirement Date: 07-01-2003 ☒ SCRS ☐ PORS ☐ GARS ☐ JSRS

Section I **SERVICE OR DISABILITY RETIREMENT INFORMATION**

Please indicate the last day the employee earned compensation or is expected to earn compensation from your agency (last day of paid employment from which employee retirement contributions were or will be deducted): 05-25-2003

Even if the employee's actual termination date from your payroll will be the same as the date given above or will be after the date given above (due to workers' compensation, disability leave of absence without pay, Teacher and Employee Retention Incentive (TERI) program participation, etc.), **please indicate the employee's actual date of termination for retirement purposes only:** 06-30-2003

Employer Name: ANY EMPLOYER Employer Code: ###.##

Completed by: AUTHORIZED REPRESENTATIVE Job Title: BENEFITS ADMINISTRATOR

Phone Number: 803-123-4567 Fax Number: 803-987-6543

Authorized Employer Signature:_____ Date: _____

Section II **FOR TEACHER AND EMPLOYEE RETENTION INCENTIVE PROGRAM PARTICIPANTS ONLY**

This is to certify that in conjunction with the above-named member's SCRS service retirement, the member and employer acknowledge the member's participation in the Teacher and Employee Retention Incentive (TERI) program on the TERI start date below and the termination of his or her participation on the TERI end date below:

TERI Start Date: _____ (DATE OF RETIREMENT) TERI End Date: _____ Number of Months: _____ (MAXIMUM OF 60 MONTHS)

_____ TERI Participant's (Employee's) Signature Date: _____

_____ TERI Employer's Authorized Signature Date: _____

* For TERI participation, this termination date should be no more than one day prior to TERI start date (effective date of retirement) so as to certify that the member was actively employed upon TERI participation. For all retirees, complete Section I. For TERI retirees, complete Sections I and II.

Please complete this form and attach it to the member's application for retirement.

Please submit a corrected copy as soon as possible should any information change. The TERI participant or employer should notify the Retirement Systems' Payroll Department, either by telephone or in writing, three months prior to the TERI participant's TERI ending date.

Form 6201
Revised 05/08/2003
Page 1 of 2

EMPLOYER CERTIFICATION OF LAST DAY PAID

State Budget and Control Board - South Carolina Retirement Systems
Customer Annuity Claims
PO Box 11960, Columbia SC 29211-1960

Please attach to retirement application or fax to - Customer Annuity Claims' Unit at 803-737-7752. The purpose of this information is to determine an effective date of retirement for estimated payroll purposes.

Retiring Member's Name: ANY RETIREE SSN: 123-45-6789

Planned Retirement Date: 06-30-2003 ☒ SCRS ☐ PORS ☐ GARS ☐ JSRS

Section I **SERVICE OR DISABILITY RETIREMENT INFORMATION**

Please indicate the last day the employee earned compensation or is expected to earn compensation from your agency (last day of paid employment from which employee retirement contributions were or will be deducted): 06-29-2003

Even if the employee's actual termination date from your payroll will be the same as the date given above or will be after the date given above (due to workers' compensation, disability leave of absence without pay, Teacher and Employee Retention Incentive (TERI) program participation, etc.), **please indicate the employee's actual date of termination for retirement purposes only:** 06-29-2003

Employer Name: ANY EMPLOYER Employer Code: ###.##

Completed by: AUTHORIZED REPRESENTATIVE Job Title: BENEFITS ADMINISTRATOR

Phone Number: 803-123-4567 Fax Number: 803-987-6543

Authorized Employer Signature:_____ Date: _____

Section II **FOR TEACHER AND EMPLOYEE RETENTION INCENTIVE PROGRAM PARTICIPANTS ONLY**

This is to certify that in conjunction with the above-named member's SCRS service retirement, the member and employer acknowledge the member's participation in the Teacher and Employee Retention Incentive (TERI) program on the TERI start date below and the termination of his or her participation on the TERI end date below:

TERI Start Date: 06-30-2003 (DATE OF RETIREMENT) TERI End Date: 05-31-2008 Number of Months: 60 (MAXIMUM OF 60 MONTHS)

_____ _____
TERI Participant's (Employee's) Signature TERI Employer's Authorized Signature

Date: _____ Date: _____

* For TERI participation, this termination date should be no more than one day prior to TERI start date (effective date of retirement) so as to certify that the member was actively employed upon TERI participation. For all retirees, complete Section I. For TERI retirees, complete Sections I and II.

Please complete this form and attach it to the member's application for retirement.

Please submit a corrected copy as soon as possible should any information change. The TERI participant or employer should notify the Retirement Systems' Payroll Department, either by telephone or in writing, three months prior to the TERI participant's TERI ending date.

Form 6201
Revised 05/08/2003
Page 1 of 2

EMPLOYER CERTIFICATION OF LAST DAY PAID

State Budget and Control Board - South Carolina Retirement Systems
Customer Annuity Claims
PO Box 11960, Columbia SC 29211-1960

Please attach to retirement application or fax to - Customer Annuity Claims' Unit at 803-737-7752. The purpose of this information is to determine an effective date of retirement for estimated payroll purposes.

Retiring Member's Name: ANY RETIREE SSN: 123-45-6789

Planned Retirement Date: 06-30-2003 ☒ SCRS ☐ PORS ☐ GARS ☐ JSRS

Section I **SERVICE OR DISABILITY RETIREMENT INFORMATION**

Please indicate the last day the employee earned compensation or is expected to earn compensation from your agency (last day of paid employment from which employee retirement contributions were or will be deducted): 05-25-2003

Even if the employee's actual termination date from your payroll will be the same as the date given above or will be after the date given above (due to workers' compensation, disability leave of absence without pay, Teacher and Employee Retention Incentive (TERI) program participation, etc.), **please indicate the employee's actual date of termination for retirement purposes only:** 06-29-2003

Employer Name: ANY EMPLOYER Employer Code: ###.##

Completed by: AUTHORIZED REPRESENTATIVE Job Title: BENEFITS ADMINISTRATOR

Phone Number: 803-123-4567 Fax Number: 803-987-6543

Authorized Employer Signature:_____ Date: _____

Section II **FOR TEACHER AND EMPLOYEE RETENTION INCENTIVE PROGRAM PARTICIPANTS ONLY**

This is to certify that in conjunction with the above-named member's SCRS service retirement, the member and employer acknowledge the member's participation in the Teacher and Employee Retention Incentive (TERI) program on the TERI start date below and the termination of his or her participation on the TERI end date below:

TERI Start Date: 06-30-2003 (DATE OF RETIREMENT) TERI End Date: 05-31-2008 Number of Months: 60 (MAXIMUM OF 60 MONTHS)

_____ TERI Participant's (Employee's) Signature

Date: _____

_____ TERI Employer's Authorized Signature

Date: _____

* For TERI participation, this termination date should be no more than one day prior to TERI start date (effective date of retirement) so as to certify that the member was actively employed upon TERI participation. For all retirees, complete Section I. For TERI retirees, complete Sections I and II.

Please complete this form and attach it to the member's application for retirement.

Please submit a corrected copy as soon as possible should any information change. The TERI participant or employer should notify the Retirement Systems' Payroll Department, either by telephone or in writing, three months prior to the TERI participant's TERI ending date.

Form 6253
Employer's Disability Employment Status Report

Form 6253
Revised 02/03/2004
Print or type in
black ink

EMPLOYER'S DISABILITY EMPLOYMENT STATUS REPORT

To Be Completed by Applicant's Payroll/Benefits Officer
State Budget and Control Board
South Carolina Retirement Systems
Attention: Customer Services Annuity Claims
PO Box 11960, Columbia, SC 29211-1960

☐ SCRS
☐ PORS
☐ GARS

The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above as soon as possible. Upon receipt of this completed form, the employee's application will be processed.

Employee Name: CINDY S TEACHER

Social Security Number: 456-98-1237

Employer: Greenville School District

Employer Code: 823.01

Position Title: Teacher

1. Is the position title shown above correct?
☒ Yes ☐ No (please explain) _____

2. Annual salary on date of disability:
$ 40,000.00

3a. Is the employee currently working?
☒ No (last day physically worked): 5-11-2003 (MM-DD-YYYY) (skip to Question 4a)
☐ Yes (proceed to Question 3b)

3b. Is the employee performing all regular duties?
☐ Yes (skip to Question 6a)
☐ No (proceed to Question 3c)

3c. In what capacity is the employee currently working?
☐ Light duty* ☐ Diminished capacity* ☐ Leave without pay (not terminated) (attach copy of Personnel Policy)
☐ Reduced hours
☐ Other (please explain): _____

*Attach letter explaining current duties in relation to normal work functions.

3d. Date member was placed in status shown at left: _____ (MM-DD-YYYY)

4a. Is this employee terminated?
☒ No (skip to Question 5)
☐ Yes (date of termination): _____ (MM-DD-YYYY)
(proceed to Question 4b)

4b. Last day compensation was earned (including pay continuation, using annual and sick leave): _____ (MM-DD-YYYY)

4c. Amount of lump-sum payments for unused leave
Annual leave $ _____
Sick leave $ _____

4d. Number of days of unused leave: (complete and proceed to Question 6a)
Annual leave _____
Sick leave _____

5. Employee's current payroll status (check one and indicate appropriate date):
☐ On annual leave (date leave began): _____
☐ On sick leave (date leave began): _____
☐ Other (please explain): _____
☒ On leave without pay (date leave began): _____
☐ Applied for leave under sick leave bank (date leave begins): _____

6a. Was this employee injured on the job?
☐ No ☒ Yes (date of injury): 4-25-2003 (MM-DD-YYYY)

6b. Is employee on leave without pay (not terminated) pending settlement of a Workers' Compensation claim?
☐ No ☐ Claim settled (date): 5-11-2003 (MM-DD-YYYY)
☐ Yes

I hereby certify that to the best of my knowledge, the information above correctly reflects the records of the employing entity.

Prepared by: JOHN TAYLOR Title: BENEFITS ADMINISTRATOR

Signature: _____ Date: _____ Telephone: _____

Return completed form to the SC Retirement Systems (address above).

Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-6800

Form 6254

Employer's Description of Disability Applicant's Job

Form 6254
Revised 04/04/2002
Print or type in black ink

EMPLOYER'S DESCRIPTION OF DISABILITY APPLICANT'S JOB

(TO BE COMPLETED BY APPLICANT'S SUPERVISOR)
State Budget and Control Board: Employee Benefits Division
South Carolina Retirement Systems
ATTENTION: CUSTOMER SERVICES ANNUITY CLAIMS
PO Box 11960, Columbia SC 29211-1960

Retirement System
☒ SCRS
☐ PORS
☐ GARS

The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above as soon as possible. Upon receipt of this completed form, the employee's application will be processed.

DISABILITY APPLICANT/EMPLOYEE INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number
TEACHER	CINDY S	456-98-1237

4. Position Title	5. Employer	6. Employer Code
TEACHER	GREENVILLE SCHOOL DIST	823.01

Date employee started this position: 08-15-2000 MM-DD-YYYY

Date employee stopped work in this position because of disability: 05-11-2003

IN THIS JOB DID THE EMPLOYEE:

1. Use machines, tools, or equipment of any kind? ☒ Yes ☐ No
2. Use technical knowledge of any kind? ☒ Yes ☐ No
3. Do any writing, complete reports, or perform similar duties? ☒ Yes ☐ No
4. Have supervisory responsibilities? ☐ Yes ☒ No

DESCRIBE BASIC DUTIES OF JOB BELOW AND **ATTACH EMPLOYEE'S POSITION DESCRIPTION.**
ALSO, EXPLAIN ALL "*YES*" ANSWERS ABOVE BY GIVING A *FULL DESCRIPTION* OF:

A. Type of machines, tools, or equipment used, and exact operations performed.
B. The technical knowledge or skills involved.
C. Type of writing done and nature of reports.
D. The number of people supervised and the extent of supervision.

Computer
Knowledge of requirements for subject taught, certification
Writing and grading of tests, writing on board
No people supervised

DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY THIS JOB INVOLVED DURING A TYPICAL DAY IN TERMS OF:

A. CHECK NUMBER OF HOURS A DAY:

	1	2	3	4	5	6	7	8
WALKING	☐	☐	☐	☒	☐	☐	☐	☐
STANDING	☐	☐	☐	☒	☐	☐	☐	☐
SITTING	☒	☐	☐	☐	☐	☐	☐	☐

B. CHECK HOW OFTEN:

	NEVER	OCCASIONALLY	FREQUENTLY	CONSTANTLY
BENDING	☐	☐	☒	☐
REACHING	☐	☐	☒	☐

C. LIFTING AND CARRYING

THIS EMPLOYEE **OCCASIONALLY** (UP TO 1/3 OF AN 8-HOUR DAY) LIFTS AND/OR CARRIES:

☒ LESS THAN 10 LBS.	Kinds of objects lifted:	Books
☒ 10 LBS.	Kinds of objects lifted:	Books
☒ 20 LBS.	Kinds of objects lifted:	Overhead projector
☐ 30 LBS.	Kinds of objects lifted:	
☐ 50 LBS.	Kinds of objects lifted:	
☐ 50 LBS. OR MORE	Kinds of objects lifted:	

THIS EMPLOYEE **FREQUENTLY** (1/3 TO 2/3 OF AN 8-HOUR DAY) LIFTS AND/OR CARRIES:

☐ LESS THAN 10 LBS.	Kinds of objects lifted:
☐ 10 LBS.	Kinds of objects lifted:
☐ 20 LBS.	Kinds of objects lifted:
☐ 30 LBS.	Kinds of objects lifted:
☐ 50 LBS. OR MORE	Kinds of objects lifted:

NAME OF SUPERVISOR (PLEASE PRINT)	TITLE
THE BOSS	PRINCIPAL

PHONE	DATE	SIGNATURE	Position Description Attached
864-165-6484	05-22-2003		☒ Yes ☐ No

Return completed form to the SC Retirement Systems (address above).
Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-6800

Claims Procedure Act

Claims Procedure Act
Effective 7/1/03

- Established under Chapter 21 of Title 9 of the SC Code of Laws
- Designed to create a more efficient and fair procedure for claim disputes
- Must file an appeal within one year of the Retirement Systems' decision
- Prohibits class action lawsuits
- Limits retroactive retirement benefit or monetary relief to one year
- Creates different procedures for appeals of disability denials and appeals of administrative decisions.

Claims Procedure Act
Administrative Appeal

Administrative Decisions	Disability Retirement Decisions
Claimant makes written appeal to Director of Retirement Systems within one year of administrative decision	Initial review by Disability Determination Provider (DDP) and Retirement Systems' Medical Board of member's application for disability retirement benefits
↓	↓
Claimant is afforded opportunity to present claim in writing to Director for review	If disability claim is denied, member may request in writing a reconsideration within 30 days from receipt of denial
↓	↓
	Member's disability claim is sent to DDP for further information development, reevaluation of claim, and recommendation to Retirement Systems' medical Board
↓	↓
	If Retirement Systems' Medical Board denies claim, member may make written appeal to Director of Retirement Systems within 30 calendar days from receipt of decision
↓	↓
	Director forwards claim to Vocational Consultant appointed by the Director for review, conference, and recommendation
↘	↙
Director makes Final Agency Determination	
↓	
Director's decision is final decision of Retirement Systems and State Budget and Control Board	
↓	
Claimant files request for contested case hearing with Administrative Law Court within 30 calendar days after receipt of Retirement Systems' final decision to seek review of Retirement Systems' Final Agency Determination	
↓	
Circuit Court, Court of Appeals, and ultimately, South Carolina Supreme Court, may review the Administrative Law Court decision	